Health Link
It's about healthy kids

Connecting Manchester's Children and Teens With Health Care Providers

A joint project of the Healthy Manchester Leadership Council and Manchester's pediatric and family practices.

I hereby authorize an exchange of information regarding my child's demographics, health insurance, doctor, lead tests, tuberculosis tests, flu shots, immunizations, and chronic medical conditions between the Manchester Health Department and (check any that apply):

- ☐ **Covering Kids & Families (for Healthy Kids application assistance)**
- ☐ **Health care provider (for help finding a doctor):**_____

(Please Print)

Patient Name [Last, First, Middle]	Date of Birth	M / F	Parent / Guardian Name [Last, First, Middle]
	/ /		

Street Address	City	Apt #	Zip Code

Home Phone Number	Work or Mobile Phone Number	E-mail
( )	( )	

Secondary Contact Name [last, first]	Secondary Phone Number	Relationship to Patient
	( )	

Best Day (s) and time (s) to Call: *M.* _____*am / pm T.* _____*am / pm W.* _____*am / pm T.* _____*am / pm F.* _____*am / pm*

School Your Child Attends	School Nurse	Grade

Sibling Last Name	Sibling First Name	DOB	M/F	School Children Attend

How Did You Hear About Health Link?

☐ School Nurse	☐ CMC Pregnancy Center	☐ Friend/Family
☐ Elliot Emergency Room	☐ CMC Emergency Room	☐ Local Community Provider
☐ Community Health Nurse	☐ Day Care	☐ Specify Other_____

Do you have reliable transportation	? Primary Language Spoken at Home?
Yes No Other:	English Spanish Other:

Check all of the races below that apply to you:

☐ **Caucasian** [Includes countries such as Ireland, Germany, Lebanon, Saudi Arabia, Poland, Bosnia, Middle Eastern countries, etc.]
☐ **Black/African American/African** [Includes countries such as Haiti, Jamaica, Kenya, Congo, etc]
☐ **Asian** [Includes countries such as China, Philippines, Bangladesh, Nepal, Pakistan, Vietnam, Indonesia, Madagascar, etc.]
☐ **Native Hawaiian or Other Pacific Islander** [Includes countries such as Hawaii, Samao, Guam, Micronesia, Tahiti, Palua, etc]
☐ **South or North American Indian or Alaska Native** [Includes countries from South America and islands such as Puerto Rico]

I consent to release of the above information to the Manchester Health Department. I further authorize the Manchester Health Department to share this information with health care providers to which my child may be referred and to other agencies as indicated above. I understand that a Health Link representative may contact my primary care provider throughout the one-year term of this agreement, for further case management. I understand this release may be revoked at any time with a written request. I understand I may request a copy of this signed release. This authorization is in effect for 1 year from date of signing.

Signature of Parent/Legal Guardian_____ Date _____

Manchester Health Department, 1528 Elm Street, Manchester, NH 03101, Tel: (603) 624-6466 x 312, Fax: (603) 624-6584